STATE OF IOWA
HEALTH FLEXIBLE SPENDING ACCOUNT
PREPAYMENT FORM

_____ _____
Last Name, First Name, MI (please print) SSN

I certify that I am participating in the State of Iowa's Health Flexible Spending Account program and that I am retiring from state employment prior to the end of the calendar year. My final paycheck will be _____. I hereby request that the State of Iowa deduct my remaining health flexible spending account annual commitment from my last paycheck. I understand that the above pays for coverage as a participant in the State's Health Flexible Spending Account Program through the end of the calendar year.

Employee's Signature: _____ Date: _____

RETURN THIS FORM TO ASI AT LEAST ONE WEEK BEFORE YOUR LAST DAY OF EMPLOYMENT

Fax to: 877-879-9038 or **Mail to:** ASIFlex
PO Box 6044
Columbia, MO 65205-6044

For more information, contact ASI at:
Phone: 800-659-3035 Email: asi@asiflex.com Website: http://www.asiflex.com

ASI USE ONLY:

Dept. 3 Digit #: _____ Amount: $_____

Human Resources Associate: _____

CFN 552-0758
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